PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Glenda E. Hood
Secretary of State
DIVISION OF CORPORATIONS

FILED
03 OCT 13 PM 2:36
SECRETARY OF STATE
TALLAHASSEE FLORIDA

DOCUMENT # **P95000045248**

1. Corporation Name

DOCTORS NEUROMUSCULAR REHABILITATION, INC.

Principal Place of Business	Mailing Address
10071 NW 7 AVE MIAMI FL 33150	10071 NW 7 AVE MIAMI FL 33150

REINSTATEMENT 03

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable		3. New Mailing Office Address, If Applicable	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. Date Incorporated or Qualified To Do Business in Florida: **06/06/1995**

5. FEI Number: **65-0570955** ☐ Applied For ☐ Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐ **$8.75 Additional Fee required for a Certificate of Status**

7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director 3	City / State / Zip 4
PD	BRASS, H. CRAIG	10071 NW 7 AVE	MIAMI FL 33150

500023764455
10/13/03--01093--011 **150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
BRASS, H. CRAIG 10071 NW 7 AVE MIAMI FL 33150	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (7/03)

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0505, F.S. or 617.0505, F.S.

Signature of Registered Agent SIGNATURE [signature] Date 10/9/03
REGISTERED AGENT MUST SIGN

11. I certify that I am an officer or director or the receiver or trustee empowered to execute this application as provided for in chapter 607 or 617, F.S. I further certify that when filing this reinstatement application, the reason for dissolution has been eliminated, the corporate name satisfies the requirements of section 607.0401 or 617.0401, F.S., that all fees owed by the corporation have been paid and the names of individuals listed on this form do not qualify for an exemption under section 119.07(3)(i), F.S. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath.

SIGNATURE: SIGNATURE [signature] 10/9/03
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Doctors Neuromuscular Rehabilitation, Inc.
SHELLY WOOLF, L.M.T.
P.O. BOX 681568
MIAMI, FL 33168
TELEPHONE: (305) 758-4353

October 9, 2003

Division of Corporations
Annual Report/Reinstatement Section
P.O. Box 6327
Tallahassee, Florida 32314-6327

Corporation name: **Doctors Neuromuscular Rehabilitation, Inc.**
Document number: **P95000045248**
FEI number: 65-0570955

To Whom It May Concern,

Attached, please find our application for reinstatement. At this time we would request that the reinstatement fee be waived as we did not receive the two prior uniform business report notices. As you can see by our record, we have never missed filing a report. Unfortunately, we never received the two notices for this year.

Thank you for your cooperation.

Very Truly Yours,

H. Craig Brass, D.C.